2011 BILLER "B" AWARE INFORMATION

December 28, 2011- Attention ALL Practitioners: Effective January 1, 2012, there will be a modification to the reimbursement methodology for specific injectable drugs for the following programs: Medicaid, Children's Special Health Care Services (CSHCS) and Maternity Outpatient Medical Services Program (MOMS).

This new methodology prices certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost. Utilization of lower cost alternative agents will have increased reimbursement over Average Sales Price (ASP) rates, with margins greater than or equal to higher cost agents within the same therapeutic class. Below is the list of drug classes and the drugs that will be affected by this new pricing methodology

- Anti-Emetics: Kytril and Zofran
- Bisphosphonates: Aredia
- Colony Stimulating Factors: Neupogen, and Leukine
- Taxanes: Taxol
- For more information about the change, please see policy bulletin # MSA 11-50 on the MDCH web site located at www.michigan.gov/medicaidproviders >> Policy and Forms >> 2011

December 20, 2011- Attention Nursing Facility Providers: MDCH will be reprocessing over 1,600 claims that were processed incorrectly. These claims involve Medicare Coinsurance Days billed to Medicaid where Occurrence Span Code 70 (Qualifying Stay Dates For Skilled Nursing Facility- SNF) was not reported. Bulletin MSA 10-03 referenced the use of Occurrence Span Code 70 which aligns with the National Uniform Billing Committee (NUBC).

December 8, 2011- Attention Inpatient and Outpatient Hospital Providers: FD 622 Report is available on CHAMPS DMS in new format. Click here to view

December 8, 2011- Attention Nursing Facility Providers: MDCH is finalizing a modification to the reimbursement methodology for Medicare Advantage Plan Co-Insurance Days. These claims may have originally been processed incorrectly. Once the modification is complete, MDCH will reprocess the affected claims on behalf of providers.

December 5th 2011- Attention Professional Providers: Effective January 1, 2012, there will be a modification to the reimbursement methodology for specific injectable drugs. This new methodology prices certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost. Utilization of lower cost alternative agents will have increased reimbursement over Average Sales Price (ASP) rates, with margins greater than or equal to higher cost agents within the same therapeutic class. This new methodology represents an opportunity for increased reimbursement. For additional information including the drugs and the programs affected, please see Policy Bulletin MSA-11-50

November 30, 2011- Attention All Providers and Billing Agents: Though CMS recently announced it will not be enforcing penalties for non-compliance of the HIPAA 5010 version, MDCH would like to clarify Michigan Medicaid's position.

MDCH does not see this as an exception to being compliant and will be requiring a full implementation to HIPAA 5010 standards on January 1, 2012.

November 30, 2011- Attention Outpatient Hospital Providers: MDCH will be reprocessing approximately 18,000 claims due to October APC software and pricing update.

November 22, 2011- Attention FQHC and RHC Providers: When completing the Health Plan detail for your Reconciliation Reports, you must report the Medicaid or MIChild issued Beneficiary ID number so eligibility can be verified. Any claim submitted for a beneficiary not enrolled with a Health Plan during that reported date of service will be excluded from your settlement.

November 16, 2011- Attention ALL Billing Agents: Effective mid-August MDCH changed and reposted a new 835 Electronic Remittance Advice Request for Billing Agent Change/Update form at the following link:

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42545_42638---,00.html . If you book marked or saved the form previously, prior to the dates above, please use this link to obtain the correct form.

When having providers fax that form to Automated Billing for processing, please use this new version. MDCH needs to have consistent information being received from all sources regarding this new 835 form.

November 9, 2011- Attention ALL Providers: Due to the implementation of HIPAA 5010, CHAMPS will experience a complete system outage beginning at 12am Friday December 30th, 2011. The system is scheduled to be back up and functional on Tuesday January 3rd, 2012 at 12am. During this 4 day outage, you will not be able to access the CHAMPS system at all.

Additionally, the last opportunity to submit a HIPAA 4010 file will be on Wednesday December 28th, 2011 at 3pm. After that only HIPAA 5010 claims will be accepted and any submitted after Wednesday December 28th, 2011 will be held during the outage and will be processed beginning on at 12am January 3rd, 2012.

To check eligibility, we suggest you use web-Denis or the Michigan Public Health Institute's (MPHI) web service for beneficiary eligibility status. An L-Letter will be published soon with further details about the CHAMPS system outage.

For questions regarding the HIPAA 5010 implementation please go to www.michigan.gov/medicaidproviders >> HIPAA 5010/ICD10 Implementation or email MDCH-5010@michigan.gov .

November 7, 2011- Attention ALL Providers: All major identified CHAMPS defects have now been fixed and released into CHAMPS production in an effort to prepare for the January 1, 2012 implementation of HIPAA 5010. Please reference the CHAMPS Provider Update Table for a current list of system fixes. The CHAMPS Provider Update Table can be found at www.michigan.gov/medicaidproviders >> CHAMPS>> CHAMPS Provider Update Table.

For those of you who have been holding batches of claims, due to system defects, and have now exceeded timely filing limits, please submit a request for timely filing bypass/acceptance no later than 12/1/2011 to providersupport@michigan.gov with the subject line: CHAMPS BATCH TIMELY DEFECTS. Please include in the body of the email the total claim count to be submitted, the range of dates of service, and an explanation for the request. All batch requests will be reviewed by MDCH for validity. Upon approval response from MDCH, batches may be submitted applicable to outstanding claims previously withheld due to system defects/issues, whereby MDCH will consider for bypass of the timely filing edit.

November 3, 2011- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a Medicaid Health Plan. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. Please review the following for information on how to verify the Adjustment Source of your claim .

November 1, 2011- Attention Vision Providers: MDCH has identified a systems issue that has caused claims for beneficiaries age 21 and older to deny incorrectly (e.g., RARC N129). This error has been corrected and claims will be adjusted by MDCH. Providers will see these claims on their remittance advice during November 2011.

October 31, 2011- Attention ALL Providers: **Reminder** : A primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., Certified Nurse-Midwife [CNM], Nurse Practitioner [NP]) can provide family planning/Plan First services. Beneficiaries eligible for this waiver are limited to the receipt of family planning services only. Family planning services are defined as any medically approved means, including diagnostic evaluation, medications, and supplies, for voluntarily preventing or delaying pregnancy. Covered services include:

- Office visits for family planning related services. This includes preventive evaluation and management office visits and other office/outpatient visits for family planning services.
- Contraceptives, including oral contraceptives and injectables.
- Contraceptive supplies and devices for voluntarily preventing or delaying pregnancy.
- Laboratory testing and pharmaceuticals related to contraceptive management or initial treatment of sexually transmitted infections (STIs).
- Sterilizations completed in accordance with current Medicaid policy.

PLEASE NOTE: Family planning/Plan First services are limited to the V25 diagnosis code series range. Providers must enter the appropriate V25 diagnosis code as the primary diagnosis on the claim form for services rendered.

October 25, 2011- Attention ALL Providers: Effective January 1, 2012, all trading partners must submit electronic healthcare transactions using the HIPAA 5010/NCPDP D.0 transaction formats. (Trading partners include: providers, clearinghouses, billing agents, vendors, and health plans.) **B2B testing is now available for all trading partners through the Ramp Manager testing website at** https://sites.edifecs.com/?michigan **. All trading partners must test and be certified through the MDCH two-stage B2B testing process in order to successfully submit 5010/NCPDP D.0 transactions to CHAMPS** . If you are not certified to submit 5010 transactions, **your claims will not be accepted and payments will not be processed.** Please see MSA 11-36.

October 25, 2011- Attention Nursing Facility Providers: MDCH is now accepting institutional crossover claims from the coordination of benefits contractor, Group Health Incorporated (GHI). The institutional nursing facility crossover claim process will allow nursing facilities to submit a single claim for residents dually eligible for Medicare and Medicaid.

After processing the Medicare portion, GHI will forward the claim to Michigan Medicaid for processing and reimbursement. Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days. The facility may check claim status online through the Community Health Automated Medicaid Processing System (CHAMPS). If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information.

October 19, 2011- Attention DME Providers: Per Biller "B" Aware posted May 9th & August 22 2011, MDCH has issued voids for over 10,000 claims.

October 17, 2011- Attention Outpatient Hospital Providers: MDCH has identified an issue with G0434 which was paying zero dollars prior to the CHAMPS release on September 9th, 2011. After the release G0434 was denying in error as per MSA policy bulletin 10-65 this is a covered code. MDCH will be reprocessing the affected claims.

October 10, 2011- Attention Home Health Providers : MDCH will be reprocessing approximately 3700 claims that were billed with G0151, G0152 G0153, G0154, G0156, 99601 and 99602 and were not processed correctly.

October 5, 2011- Attention Nursing Facility Providers: THE NURSING FACILITY INSTITUTIONAL CROSSOVER CLAIM PROCESS IS DELAYED UNTIL OCTOBER 10, 2011 - OCTOBER 17, 2011 AT THE LATEST.

The Michigan Department of Community Health apologizes for this delay and inconvenience. Medicaid Bulletin MSA 11-32, issued August 1, 2011 indicated that in fall 2011 that the Michigan Department of Community Health (MDCH) would be accepting nursing facility institutional crossover claims from the coordination of Medicare benefits contractor, Group Health Incorporated (GHI).

In September 2011, notice was issued on Medicaid LISTSERVE and Biller "B" Aware advising nursing facilities that effective October 1, 2011, MDCH would begin accepting crossover claims from GHI.

Any questions regarding this message can be directed via e-mail to: ProviderSupport@michigan.gov . Please include your name, affiliation, and phone number. Nursing facilities may also phone toll-free 1-800-292-2550.

October 5, 2011- Attention ALL Providers- MDCH will be reprocessing approximately 12,000 PAID claims for beneficiaries that have dual Benefit Plans, MA-ESO and CSHCS or MA-ESO and MOMS. If your claims denied for this reason, you must rebill your claim. These claims may have originally been processed incorrectly.

October 5, 2011- Attention Outpatient Providers - MDCH will be reprocessing approximately 21,000 claims due to April/ July APC software and pricing update.

September 28, 2011- Attention Hospital Providers: MDCH is pleased to announce the availability of the FD-622 Reports in a downloadable electronic format (pdf). The reports will be available for pay date cycles after October 1, 2011. In order to achieve savings, effective October 1, 2011 MDCH will cease to mail paper copies of the FD-622 to inpatient hospital, outpatient hospital, end stage renal dialysis centers, and outpatient rehabilitation facilities.

The reports are available through CHAMPS archived documents.

If you have difficulty accessing the report, please call provider hotline for assistance.

September 26, 2011- Attention ALL Providers: Revised Benefit Plan Handout with Service Type Codes *Updated 9/2011

September 21, 2011- Attention Nursing Facilities: Medicare - Medicaid Nursing Facility Crossover Claims with Group Health Incorporated (GHI) (Coordination of Benefits)

Medicaid Bulletin MSA 11-32, issued August 1, 2011 indicated that in fall 2011 that the Michigan Department of Community Health (MDCH) would be accepting nursing facility institutional crossover claims from the coordination of Medicare benefits contractor, Group Health Incorporated (GHI).

This notice is to advise nursing facilities that effective October 10, 2011, MDCH will begin accepting crossover claims from GHI. As such, claims that include Medicare as the primary payer and Medicaid as the secondary payer, will be crossed over to Medicaid from GHI.

To avoid duplicate claim rejections and delay in payment, nursing facilities must avoid direct billing to Medicaid. Medicaid asks that nursing facilities await their Medicare RA for claim submission dates effective October 10, 2011. Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days.

The following website provides more information and frequently asked crossover question: www.michigan.gov/medicaidproviders >>Billing and Reimbursement >>Medicare Crossover.

Any questions regarding this message can be directed via e-mail to: providerSupport@michigan.gov. Please include your name, affiliation, and phone number. Nursing facilities may also phone toll-free 1-800-292-2550.

September 8, 2011- Attention ALL Providers: MDCH has scheduled Michigan Medicaid Trainings and Champs Navigational sessions in the Upper Peninsula, Marquette MI during the last week of September 2011.

These sessions will offer specific training to providers with an opportunity to have a one on one session with a Medicaid Provider Liaison (note: one on one session time may be limited based on number of registered providers). To register for an AM or PM session, visit our training website at www.michigan.gov/medicaidproviders >> Communication and Training >> Medicaid Provider Training Sessions.

August 30, 2011- Attention Outpatient Hospital Providers: Outpatient Hospital Providers with service lines denied with Reasons code 11 and Remark code N10 - may wish to adjust or re-bill their claim with documentation supporting the medical necessity of the procedure code. The documents should be sent into EZ LINK and should include: Ultrasound, MRI, CAT scan, History and Physical, ER Report.

August 30, 2011- Attention ALL Providers: Providers may wish to re-bill for TPL take backs done in error but have dates of service over one year old. Please indicate in the remarks/comments section of your invoice the TCN/pay-cycle date of the void transaction that TPL used to take back the money.

Example: (4111xxx8xxxxxxx000 / pay-cycle date 08/25/2011 TPL take back in error)

The re-bill is due within 365 days from the date of the TPL take back done in error. Information supplied on the invoice will be verified.

August 29, 2011- Attention Professional Providers: MDCH has identified an issue with the reimbursement rates for the CPT codes activated for January 2011, as listed in Bulletin MSA 10-65. Rates have been re-calculated to reflect CMS's updated National Physician Fee Schedule Relative Value

File for dates of service on or after January 1, 2011. MDCH has posted a revised Practitioner and Medical Clinic Database and will be reprocessing the affected claims on behalf of the providers.

Professional Providers are also advised that payment status indicators related to CPT procedure codes (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.) can be referenced at the CMS website: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx .

August 22, 2011- Attention ALL Providers and Billing Agents: With CHAMPS provision for automated/electronic processes, the Automated Billing phone number (877-672-3483) has been disconnected. You can reach Electronic Data Interchange (EDI) support services/Automated Billing for any questions or issues about electronic transactions with Medicaid by e-mail at AutomatedBilling@Michigan.gov.

August 22, 2011- Attention DME Providers: UPDATED MDCH has identified a problem with claims that were incorrectly paid to DME providers when the Beneficiary has LOC 02 (Nursing Facility). Medical supplies, accessories, and durable medical equipment necessary to achieve the goals of the beneficiarys plan of care are included in the Nursing Facilitys per diem rate and are not payable to DME providers. MDCH will begin voiding these claims August 22, 2011.

August 17, 2011- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a Medicaid Health Plan. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. Please review the following for information on how to verify the Adjustment Source of your claim .

August 12, 2011- Attention Nursing Facilities: Long-Term Care Insurance- The Coordination of Benefits Chapter in the Medicaid Provider Manual states that federal regulations require all identifiable resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a Medicaid beneficiary has long-term care insurance, it is recognized as another resource and that resource must be billed prior to billing Medicaid.

In the event the facility is aware that a beneficiary has another resource (including long-term care insurance) but the resource is not reflected on the mihealth card or the Community Health Automated Medicaid Processing System (CHAMPS) eligibility inquiry, the facility must fill out form DCH-0078. This form can be found online at www.michigan.gov/medicaidproviders>> Policy and Forms >> Forms. The preferred method of submission is by fax to Medicaid Third Party Liability (TPL) at: 517-346-9817. While fax is preferred, the form may also be sent via e-mail to tpl_health@michigan.gov . The form should be submitted before billing Medicaid. If known, please include the policy's per diem payment amount in the comments section of the form. Medicaid TPL will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The facility should bill the other resource first. Once payment has been received, the facility may bill Medicaid. The billing to Medicaid must include the payment amount received from the other resource.

August 5, 2011- Attention ALL Providers: MDCH will be reprocessing approximately 4000 claims that were billed with Modifier 54 and were not processed correctly.

August 4, 2011- Attention ALL Providers: Per Biller "B" Aware posted July 19 2011, MDCH has identified a systems issue that is causing claims to deny incorrectly with Limit or Duplicate Edits. (IE: CARC 18, B5, B13, RARC B130, N10). Claims are setting these edits against different provider types in error. MDCH has corrected this error and claims will be adjusted by MDCH on a future remittance advice.

July 29, 2011- Attention Inpatient Hospital Providers: Subsequent to the June 2011 CHAMPS release it has been reported that our MIP suppression rules have been overlooked for Medicare covered claims.

Upon system correction all affected claims will be re-processed. As soon as this problem is corrected a new Biller B Aware will be posted.

July 27, 2011- Attention ALL Providers: The issue with the TPL Recovery Letters within the Archived Documents link in CHAMPS has been resolved. Providers should now be able to access these documents directly in CHAMPS.

July 27, 2011- Attention DMEPOS Providers: When billing equipment and supplies that must be reported as a daily rate (by entering total number of days used as units); it is recommended that providers use "span" dates. For example: S5498 (home infusion therapy catheter care/maintenance). If dates of service are July 15, 2011 through August 13, 2011; the dates should be reported using the "From" and "To" dates of 07/15/2011 - 08/13/2011 and report 30 units.

July 26, 2011- Attention ALL Providers: MDCH has identified that Providers are unable to access the TPL Recovery Letters within the Archived Documents link in CHAMPS. Please continue to check this site for an update on when this issue has been resolved. In the interim, all reports continue to be mailed to the correspondence address within the Provider Enrollment file.

July 25, 2011- Attention Nursing Facility Providers: MDCH has identified claims denying Reason Code 18 and Remark code N185 on some lines for ancillary services, once the system has been corrected the claims will be adjusted by MDCH.

July 19, 2011- Attention ALL Providers: MDCH has identified a systems issue that is causing claims to deny incorrectly with Limit or Duplicate Edits. (IE: CARC 18 B5 B13 RARC B130 N10). Claims are conflicting against different provider types in error. Please review the claim limit list at the line level in the Inquire Claim screen detail to confirm whether a claim has been affected by this error. As soon as this problem is corrected a new Biller B Ware will be posted.

June 30, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with codes G0380-G0384 and G0379. MDCH reprocessed approximately 4000 affected claims and providers should see those claims on their remittance advice dated June 30th.

June 27, 2011- Attention ALL Providers: MDCH has identified an issue with some claims from Tuesday, 6/21 which were submitted prior to the cut off time of 4 p.m. It appears the claims, were received within the correct time frame, however did not complete processing in Champs. The issue has been addressed and these claims should be released by next pay cycle. There is no need to resubmit any claims.

June 21, 2011- Attention Inpatient Hospital Providers: With the July 1st implementation of the Present on Admission requirement - Providers need to submit POA values on IPH claims.

June 20, 2011- Attention ALL Providers: Effective August 1st, 2011 the Department of Technology, Management and Budget (DTMB) will be implementing new password policies for all users that access the Single-Sign On (SSO) web portal for the CHAMPS system. All users will be required to change their passwords to the new configuration when their existing password expires. The new password configuration/requirement is:

1. **Minimum password length is eight (8).**
2. **Password must contain at least one letter and one number.**
3. **Passwords are case sensitive.**
4. **Maximum number of repeated characters is two (2).**
5. **Password cannot be same as userid or user name.**
6. **New password cannot be same as current password.**

The SSO New Password Configuration instructions can be found on the MDCH website www.michigan.gov/medicaidproviders >>CHAMPS >>RESOURCES

June 16, 2011- Attention ALL Providers: Beginning in July 2011, The Third Party Liability (TPL) Division will be completing claim voids on claims where Blue Cross Blue Shield coverage has been identified after the claim has been processed by Michigan Medicaid.

Providers should begin to see these on the BCBS recovery reports, which will be available in early July 2011 through the Archived Documents link. Providers will have 30 days to contact TPL if you have reason to believe that the claim void should not be completed by MDCH. After 30 days, the claim will be voided in CHAMPS and providers are expected to bill BCBS as primary and re-bill MDCH as the secondary payer if necessary.

The recovery reports are available in CHAMPS >> MY INBOX >> ARCHIVED DOCUMENTS >> in the Document TYPE field select: TPL RECOVERY

June 13, 2011- Attention ALL Providers: **UPDATED** Archived documents from CHAMPS, such as Remittance Advices, will not be available for viewing or download for a period of time beginning Thursday, June 16, 2011 at 7:30 PM and ending Friday, June 24, 2011. This is due to a system upgrade that will take place on State of Michigan file management servers.

June 8, 2011- Attention ALL Providers: The Third Party Liability (TPL) Division will be issuing claim adjustments/voids on claims where they have found another payer as primary over Michigan Medicaid. Prior to these adjustments/voids being done, TPL will mail a recovery report to the providers Correspondence Mailing address on file. These letters will also be available in CHAMPS >>>MY INBOX>>> ARCHIVED DOCUMENTS >>>>in the Document TYPE field select: TPL RECOVERY

*Only contact TPL regarding adjustments if you have received a letter and are questioning the TPL recovery

If you are inquiring on an adjustment on your remittance advice, please click here for instructions on how to verify Adjustments Source.

June 6, 2011- Attention Home Health Providers: MDCH has identified a problem with claims processing incorrectly for Home Health Visits. Overpayments have been identified on procedures G0151, G0152 G0153, G0154, G0156, 99601 and 99602. Per Michigan Medicaid Policy providers can report up to two visits on the same day (i.e., two visits on the same day must be billed on individual lines of the same claim). MDCH will be initiating adjustments in the near future for all claims that did not meet this criteria.

June 3, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with procedure code Cxxxx billed with revenue code 027x denying with Remark code N56 (Procedure code billed is not correct/valid for the services billed or the date of service billed.). MDCH will reprocess the affected claims on behalf of providers after the error has been resolved.

June 2, 2011- Attention Hospital Providers: Providers should note that without proper consent forms for sterilizations (current Medicaid beneficiary or possible retro-eligible beneficiary) they run the risk of non-payment.

June 1, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with codes G0380-G0384 and G0379. MDCH will reprocess the affected claims on behalf of providers.

June 1, 2011- Attention Outpatient Hospital Providers: MDCH has identified a systems issue with codes Q2035-Q2039. MDCH will reprocess the affected claims on behalf of providers after the error has been resolved.

May 18, 2011- Attention Professional Providers: Subsequent observation care codes 99224, 99225, 99226 are currently non-covered services based upon current Medicaid policy. Medicaid covers physician services for beneficiaries admitted and discharged from observation status in the hospital setting for a stay less than 24 hours.

All nationally recognized codes are added to the CHAMPS reference file --with activation only as applicable to the Medicaid program's implementation of the State Health Plan and policy. Medicaid, as a state governed program, has different eligibility requirements and offers different benefits from the federally governed Medicare. While the two separate programs share many similar regulatory requirements, the Medicaid program does operate within federal guidelines.

May 9, 2011- Attention DME Providers: MDCH has identified a problem with claims that were incorrectly paid to DME providers when the Beneficiary has LOC 02(Nursing Facility). Medical supplies, accessories, and durable medical equipment necessary to achieve the goals of the beneficiarys plan of care are included in the Nursing Facilitys per diem rate and are not payable to DME providers. MDCH will be initiating voids in the near future for all claims that meet this criteria.

April 29, 2011- Attention ALL Providers: MDCH has issued voids on claims paid in error for beneficiaries that had MA-ESO (emergency services only) benefit plans. These claims did not meet the emergency criteria and originally should have been denied. Beneficiaries that have dual Benefit Plans, MA-ESO and CSHCS or MA-ESO and MOMS may have been voided in error by MDCH. MDCH is aware there are still claims not processing correctly with the Benefit Plans listed above and is currently working to resolve the issues in a future release. MDCH will post the information when corrected on our website and via ListServ message. For instructions on how to sign up for the LIST SERV notifications please go to the website at www.michigan.gov/medicaidproviders and click on >>> LISTSERV SUBSCRIPTION INSTRUCTIONS <<<

April 14, 2011- Attention MIHP Providers: MDCH inadvertently initiated newborn recovery take backs on services provided by MIHP providers. Unfortunately, there is no way for CHAMPS to reverse this error so the claims can not be resurrected or reprocessed internally. MDCH is asking providers to re-bill the affected claims. Please add the following note to your claims to expedite processing of the affected claims: **newborn void error.**

April 4, 2011- Attention ALL Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a health plan with dates of service on or after 06/01/2009 paid through 09/30/2010. Note: This quarterly batch is larger than previous batches as MDCH has not done a quarterly recovery since September 2009 due to CHAMPS go live and associated defects. Recoveries started on Pay Cycle 13. Please note, as with previous quarterly newborn take backs, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. If you have questions regarding specific claims or need assistance, please contact MDCH Provider Inquiry at (800) 292-2550 or via e-mail at ProviderSupport@michigan.gov.

April 1, 2011- Attention DMEPOS and Hospice providers: The Medical Services Administration has identified a problem with some Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims when the beneficiary is LOC 16 (hospice). DMEPOS providers must not bill Medicaid for supplies related to the treatment of the beneficiary's terminal illness. These supplies are the responsibility of the hospice and as such are included in the hospice per diem rate. Additionally, if a hospice beneficiary resides in a nursing facility (NF), claims for DME/supplies are subject to denial or post payment review because most medical supplies and/or DME are considered as part of the facility's per diem rate, or may be included in the hospice per diem rate.

March 15, 2011- Attention Professional Providers: The latest batch of MDCH Quarterly Newborn Recoveries is currently being processed. This batch includes fee for service claims for newborns who were retroactively enrolled into a health plan with dates of service on or after 06/01/2009 paid through 09/30/2010. Note: This quarterly batch is larger than previous batches as MDCH has not done a quarterly recovery since September 2009 due to CHAMPS go live and associated defects. Recoveries will begin on Pay Cycle 13. Please note, as with previous quarterly newborn takebacks, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remittance Advice date. If you have questions regarding specific claims or need assistance, please contact MDCH Provider Inquiry at (800) 292-2550 or via e-mail at ProviderSupport@michigan.gov .

March 10, 2011- Attention ALL Providers: IMPORTANT NOTICE on Claim Adjustment Reports

February 23, 2011- Attention Critical Access Hospital Providers: MDCH has identified an issue with duplicate paid claims in error.

ISSUE: CAH Providers are billing their professional charges on the institutional claim using the Professional Fee Revenue Codes in error. MDCH is paying both the professional fee revenue code service line(s) in addition to the facility charge service lines for same the service which is causing duplicate payments.

RESOLUTION: For the interim solution and to prevent duplicate payments, MDCH will be issuing VOIDS for all claims paid in error. Once the voided claim appears on your Remittance Advice, providers can resubmit the claims properly. Providers must bill professional fees on a professional claim and institutional fees on institutional claim to receive appropriate payment.

February 16, 2011- Attention Inpatient Providers: There were some technical issues with DSH payments that have been resolved. Providers should receive their payments by the 22nd or 23rd.

February 16, 2011- Attention Nursing Facility Providers: MDCH has identified an issue with Nursing Facility Therapy claims that processed at an incorrect rate. MDCH is currently collecting the data necessary to reprocess the affected claims on behalf of the providers. This will affect all Nursing Facility Therapy claims from dates of service 07/01/09 and forward. These claims will be reprocessed using the most current claims logic. If your claim was previously processed under the outdated logic, it will now be adjudicated based on current CHAMPS editing.

February 14, 2011- Attention Medicaid Inpatient and Outpatient Providers: MDCH has identified an issue with duplicate claims. Providers are submitting secondary claims when Medicare is the primary payer to Michigan Medicaid and the same claim also comes to Medicaid through the Crossover process. Medicaid will process crossover claims first and deny any duplicate claim received directly from the provider. We would like to remind all providers: **Please do not submit duplicate claims.** If the Medicare crossover claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information.

January 27, 2011- Attention Ambulance Providers: MDCH is reprocessing all denied transportation claims with valid diagnosis codes for Health Plan beneficiaries. Ambulance Providers are also reminded to review the policy manual for the reporting of Multiple Transports per Beneficiary, specifically the requirements regarding Modifier 22 and the detailing in remarks or via an EZ-link attachment.

January 27, 2011- Attention Hospice Providers: Hospice claims are being submitted with Value Code 66 to report the Patient Pay Amount (PPA). Although this was acceptable under legacy, CHAMPS does not accept the use of Value Code 66 to report the PPA. Per the National Uniform Billing Committee (NUBC), Value Code 66 is only to be used when reporting the Medicaid Spend Down Amount (Deductible). **Value Code D3, Patient Estimated Responsibility, must be used to report the PPA.**

January 24, 2011- Attention ALL Providers: MDCH will be reprocessing 250,000 professional claims that were processed incorrectly due to an age calculation issue. MDCH will also be reprocessing approximately 200,000 outpatient Medicare secondary claims that were processed at an incorrect payment since CHAMPS go live.

These claims will be reprocessed using the most current claims logic. If your claim was previously processed under the outdated logic, it will now be adjudicated based on current CHAMPS editing. This may cause some claim lines that previously paid to reject, requiring the provider to add additional information and resubmit as new or an adjustment claim. For example: if claim paid in 2010 without a NDC and there was an issue with the age calculation; the newly reprocessed claim may now deny because the NDC was not originally reported.

January 20, 2011- Attention Professional Invoice Providers: MDCH is attempting to resolve outstanding issues regarding the processing and payment of Medicare crossover claims in the upcoming releases. For the January 21 release, MDCH plans to implement changes to the logic which will allow procedure codes covered by Medicare but not covered by Medicaid to process through the system (CARC 204 & RRC N30 will no longer post).

However, as a result of this update, some claims will deny with CARC 8 & RRC N65. These denials will be reprocessed by MDCH after Friday January 25, 2011 when the logic is updated in CHAMPS.

Furthermore, MDCH will be making additional changes on March 4, 2011 to allow Medicare Crossover claims suspended with CARC 133 to process without manual review. Claims which have been paid at a decreased rate due to limit quantities will pay appropriately (CARC B5, RRC N10 or N130).

Please see the provider update table for modifications to this schedule.

January 19, 2011- Attention ALL Providers: Beginning in early spring 2011, The Third Party Liability (TPL) Division will be completing claim adjustments/voids on claims where Blue Cross Blue Shield coverage has been identified after the claim has been processed by Michigan Medicaid.

This adjustment/void process will begin with a small batch of inpatient hospital claims and providers should begin to see these on the inpatient BCBS recovery reports, which will be mailed in early February 2011. Providers will have 30 days to contact TPL if you have reason to believe that the claim adjustment/void should not be completed by the MDCH. After 30 days, the claim will be voided in CHAMPS and providers are expected to bill BCBS as primary and re-bill MDCH as the secondary payer if necessary. TPL expects to automate this process for inpatient providers beginning in March 2011, which will void claims in April 2011. Additional provider types will be added in the future as TPL moves towards this BCBS claim adjustment/void process.

January 10, 2011- Attention ALL Providers: All providers should contact Third Party Liability (TPL) to report any changes (including new coverage or terminations) in other insurance information **prior to submitting a claim to Medicaid**.

All requests should be processed by TPL within 10 business days. After the information has been updated, the claim can then be submitted with the appropriate other insurance information reported, thus avoiding unnecessary suspends because the other insurance information has been properly updated in CHAMPS.

Please submit all requests to TPL by completing the DCH-0078 form found on the TPL website at www.michigan.gov/medicaidproviders >>Billing and Reimbursement>>Third Party Liability>> Health Insurance. Fax the completed form along with any supporting documentation to 517-346-9817 (preferred option) or email the form to TPL_Health@michigan.gov .